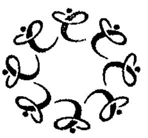

Kaiser Permanente

HMO Plan Summaries: 2019
Effective Date January 1, 2019 - December 31, 2019
Important Notes:
- No Changes for 2019

Kaiser 5 not available - only for groups who have previously selected it.

Benefit Summary	Kaiser 5 Rx: $5/$10 30-day What You Pay	Kaiser 10 Rx: $10/$20 30-day What You Pay	Kaiser 10 w/Vision Rx: $10/$20 30-day with vision What You Pay	Kaiser 10 Rx: $10/10 100-day What You Pay	Kaiser 15 Rx: $10/$20 30-day What You Pay	Kaiser 20 Rx: $15/$30 30-day What You Pay	Kaiser 30 Rx: $15/$30 30-day What You Pay
Deductible (individual/family)	None	None	None	None	None	None	None
Annual Out-of-Pocket Maximum (individual/family)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000
Rx Out-of-Pocket Maximum (individual/family)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Health Reimbursement Account	None	None	None	None	None	None	None
PCP Office Visit	$5 copay	$10 copay	$10 copay	$10 copay	$15 copay	$20 copay	$30 copay
Specialist Office Visit	$5 copay	$10 copay	$10 copay	$10 copay	$15 copay	$20 copay	$30 copay
Preventive Care Office Visit	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Mental Health Services (outpatient/inpatient)	$5 copay/No charge	$10 copay/No charge	$10 copay/No charge	$10 copay/No charge	$15 copay/No charge	$20 copay/No charge	$30 copay/No charge
Substance Abuse Services outpatient/inpatient)	$5 copay/No charge	$10 copay/No charge	$10 copay/No charge	$10 copay/No charge	$15 copay/No charge	$20 copay/No charge	$30 copay/No charge
Infertility (outpatient consult/surgery)	$5 copay	$10 copay	$10 copay	$10 copay	$15 copay	$20 copay	50% coinsurance
Outpatient Diagnostic Laboratory and Radiology (standard procedures)	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Complex Radiology (MRI & PET)	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient Surgery	$5 copay	$10 copay	$10 copay	$10 copay	$15 copay	$20 copay	$30 copay
Outpatient Physical/Rehabilitation Therapy	$5 copay	$10 copay	$10 copay	$10 copay	$15 copay	$20 copay	$30 copay
Urgent Care (Kaiser Facility)	$5 copay	$10 copay	$10 copay	$10 copay	$15 copay	$20 copay	$30 copay
Emergency Room (Copay waived if admitted)	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$100 copay
Retail Prescription Drugs (generic/brand)	$5 copay/$10 copay (up to a 30-day supply)	$10 copay/$20 copay (up to a 30-day supply)	$10 copay/$20 copay (up to a 30-day supply)	$10 copay (up to a 100-day supply)	$10 copay/$20 copay (up to a 30-day supply)	$15 copay/$30 copa (up to a 30-day supply)	$15 copay/$30 copay (up to a 30-day supply)
Mail Order Prescription Drugs (generic/preferred/non-preferred)	$10 copay/$20 copay (up to a 100-day supply)	$20 copay/$40 copay (up to a 100-day supply)	$20 copay/$40 copay (up to a 100-day supply)	$10 copay (up to a 100-day supply)	$20 copay/$40 copay (up to a 100-day supply)	$30 copay/$60 copay (up to a 100-day supply)	$30 copay/$60 copay (up to a 100-day supply)
Chiropractor Services[1]	$10 copay	$10 copay	$10 copay	$10 copay	$20 copay	$20 copay	$30 copay

[1]Services must be medically necessary and may be subject to prior authorization from OptumHealth

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UnitedHealthcare Select Plus PPO Premium Designation

Select Plus PPO Plan Summaries: 2019
Effective Date January 1, 2019 - December 31, 2019
Important Notes:
- No Changes from 2018

Benefit Summary	Select Plus PPO (SD) 80/50 - No HRA In Network What You Pay	Select Plus PPO (SD) 80/50 - No HRA Out of Network What You Pay	Select Plus PPO (SD) 80/50 - With HRA In Network What You Pay	Select Plus PPO (SD) 80/50 - With HRA Out of Network What You Pay
Deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$2,500/$2,500	$2,500/$2,500
Medical Out-of-Pocket Maximum (individual/family)	$5,000/$10,000	$5,000/$10,000	$5,000/$5,000	$5,000/$5,000
RX Out-of-Pocket Maximum (individual/family)	$1,600/$3,200	N/A	$1,600/$3,200	N/A
Health Reimbursement Account	None	None	$500	$500
PCP Office Visit	**Tier 1 Physician:** $30 copay **Other In-Network Physician:** 20% coinsurance after deductible	50% coinsurance (after deductible)	**Tier 1 Physician:** $30 copay **Other In-Network Physician:** 20% coinsurance after deductible	50% coinsurance (after deductible)
Specialist Office Visit	**Tier 1 Physician:** $50 copay **Other In-Network Physician:** 20% coinsurance after deductible	50% coinsurance (after deductible)	**Tier 1 Physician:** $50 copay **Other In-Network Physician:** 20% coinsurance after deductible	50% coinsurance (after deductible)
Preventive Care	No charge	No coverage for non-network services	No charge	No coverage for non-network services
Inpatient Hospital Care	20% coinsurace (after deductible)	50% coinsurance with Prior Authorization (after deductible)	20% coinsurace (after deductible)	50% coinsurance with Prior Authorization (after deductible)
Mental Health Services (outpatient/inpatient)	$30 copay/ 20% coinsurance (after deductible)	50% coinsurance (after deductible)	$30 copay/ 20% coinsurance (after deductible)	50% coinsurance (after deductible)
Substance Abuse Services (outpatient/inpatient)	$30 copay/ 20% coinsurance (after deductible)	50% coinsurance (after deductible)	$30 copay/ 20% coinsurance (after deductible)	50% coinsurance (after deductible)
Infertility	Not covered	Not covered	Not covered	Not covered
Outpatient Diagnostic Laboratory and Radiology (standard procedures) *Freestanding Facility or Physician Office*	No charge	50% coinsurance (after deductible)	No charge	50% coinsurance (after deductible)
Hopital-based Lab or Radiology	20% coinsurance (deductible does not apply)		20% coinsurance (deductible does not apply)	
Complex Radiology (PET & MRI) *Freestanding Facility or Physician Office*	20% coinsurance (after deductible)	50% coinsurance (after deductible)	20% coinsurance (after deductible)	50% coinsurance (after deductible)
Hopital-based Lab or Radiology	20% coinsurance plus $100 copayment (after deductible)		20% coinsurance plus $100 copayment (after deductible)	
Outpatient Surgery *Ambulatory Surgery Center or Physician's Office*	20% coinsurance (after deductible)	50% coinsurance (after deductible) Pre-authorization is required	20% coinsurance (after deductible)	50% coinsurance (after deductible) Pre-authorization is required
Outpatient Hospital-based Surgical Center	20% coinsurance (after deductible) and $100 copayment		20% coinsurance (after deductible) and $100 copayment	
Outpatient Physical/Rehabilitation Therapy (PCP/Specialist)	$30 copay	50% coinsurance (after deductible)	$30 copay	50% coinsurance (after deductible)
Urgent Care (your medical group/other medical group)	$50 copay	50% coinsurance (after deductible)	$50 copay	50% coinsurance (after deductible)
Emergency Room (Copay waived if admitted)	$100 copay	$100 copay	$100 copay	$100 copay
Short-Term Prescription Drugs[1 & 2] *(up to 3 refills and up to 30 day supply)* generic/preferred/non-preferred drugs Filled at EAN Pharmacy	$10/$30/50%* ($5 extra if filled at non-EAN pharmacy)	No coverage for non-network pharmacy	$15/$35/50%* ($5 extra if filled at non-EAN pharmacy)	No coverage for non-network pharmacy
Maintenance Prescription Drugs[3] *(4th and following fills for up to 90 day supply)* generic/preferred/non-preferred drugs Filled at Smart90 Pharmacy (Costco or RiteAid) or Express Scripts Mail Order	$20/$60/50%**	No coverage for non-network pharmacy	$30/$70/50%**	No coverage for non-network pharmacy
Chiropractor and Acupuncture Services[4]	$30 copay	50% coinsurance (after deductible)	$30 copay	50% coinsurance (after deductible)

[1] Pay standard copays if you fill your prescription at an EAN Pharmacy(EAN Pharmacies include Costco, Ralphs, Vons, Haggen, Kmart, Safeway, SuperValue, WinnDixie, Walmart, and many independent pharmacies) visit www.Express-scripts.com for a complete list of EAN pharmacies
[2] Pay standard copays plus $5/prescription if you fill your prescription at a non-EAN Pharmacy (Non-EAN Pharmacies include CVS, Walgreens, and certain independent pharmacies)
[3] You will pay the Retail Refill Allowance (RRA) penalty (equal to 2 times short-term medication copay for 30-day supply) if you fill maintenance prescriptions at a network pharmacy other than Smart90 or Express Scripts Mail Order.
[4] Services must be medically necessary and may be subject to prior authorization from OptumHealth
*Subject to a $40 minimum and $175 maximum
**Subject to a $80 minimum and $350 maximum ***Subject to a $45 minimum and $180 maximum

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CALIFORNIA SCHOOLS VEBA

UnitedHealthcare Signature Value Alliance

Alliance HMO Plan Summaries

Effective Date January 1, 2019 - December 31, 2019

Important Notes:

- Changes Highlighted in Red

Benefit Summary	Alliance HMO $500 HRA What You Pay	Alliance HMO $1200 HRA What You Pay
Deductible (individual/family)	$2,000/$2,000	$2,000/$2,000
Medical Plan Out-of-Pocket Maximum (individual/family)	$5,000/$5,000	$3,000/$6,000
RX Plan Out-of-Pocket Maximum (individual/family)	$1,600/$3,200	$1,600/$3,200
Health Reimbursement Account	$500	$1,200
PCP Office Visit	$35 copay	$35 copay
Specialist Office Visit	$50 copay	$50 copay
Preventive Care	No charge	No charge
Inpatient Hospital Care	20% coinsurance (after deductible)	20% coinsurance (after deductible)
Mental Health Services (outpatient/inpatient)	$40 copay/ 20% coinsurance (after deductible)	$40 copay/ 20% coinsurance (after deductible)
Substance Abuse Services(outpatient/inpatient)	No charge	No charge
Infertility	Not covered	Not covered
Outpatient Diagnostic Laboratory (standard procedures)	No charge	No charge
Diagnostic and Complex Radiology (PET, MRI)	20% coinsurance (after deductible)	20% coinsurance (after deductible)
Outpatient Surgery	20% coinsurance (after deductible)	20% coinsurance (after deductible)
Outpatient Physical/Rehabilitation Therapy	$35 copay	$35 copay
Urgent Care (your medical group/other medical group)	$35 copay/ 20% coinsurance(after deductible)	$35 copay/ 20% coinsurance(after deductible)
Emergency Room (Copay waived if admitted)	$300 Copay (after deductible)	$300 Copay (after deductible)
Short-Term Prescription Drugs[1 & 2] (up to 3 refills and up to 30 day supply) generic/preferred/non-preferred drugs Filled at EAN Pharmacy	$10/$30/50%* ($5 extra if filled at non-EAN pharmacy)	$10/$30/50%* ($5 extra if filled at non-EAN pharmacy)
Maintenance Prescription Drugs[3] (4th and following fills for up to 90 day supply) generic/preferred/non-preferred drugs Filled at Smart90 Pharmacy (Costco or RiteAid) or Express Scripts Mail Order Home Deliver	$20/$60/50%**	$20/$60/50%**
Chiropractor Service[4]	$30 copay	$30 copay

[1]Pay standard copays if you fill your prescription at an EAN Pharmacy(EAN Pharmacies include Costco, Ralphs, Vons, Haggen, Kmart, Kroger, Safeway, SuperValue, WinnDixie, Walmart, and many independent pharmacies) visit www.Express-scripts.com for a complete list of EAN pharmacies

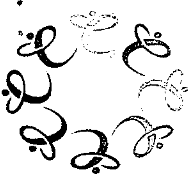
[2]Pay standard copays plus $5/prescription if you fill your prescription at a non-EAN Pharmacy (Non-EAN Pharmacies include CVS, Walgreens, and certain independent pharmacies)

[3]You will pay the Retail Refill Allowance (RRA) penalty (equal to 2 times short-term medication copay for 30-day supply) if you fill maintenance prescriptions at a network pharmacy other than Smart90 or Express Scripts Mail Order.

[4]Services must be medically necessary and may be subject to prior authorization from OptumHealth

*Subject to a $40 minimum and $175 maximum

**Subject to a $80 minimum and $350 maximum



CALIFORNIA SCHOOLS VEBA

SIMNSA HMO

San Diego HMO Plan Summaries: 2019

Effective Date January 1, 2019 - December 31, 2019

Important Notes:

- No Changes from 2018

Benefit Summary	SIMNSA HMO
Deductible *(individual/family)*	None
Medical Plan Out-of-Pocket Maximum (individual/family)	$6,350/$12,700
RX Plan Out-of-Pocket Maximum (individual/family)	N/A
Health Reimbursement Account	None
PCP Office Visit	$5 copay
Specialist Office Visit	$5 copay
Preventive Care	No charge
Inpatient Hospital Care	No charge
Mental Health Services *(outpatient/inpatient)*	$5 copay/ No charge
Substance Abuse Services *(outpatient/inpatient)*	$5 copay/ No charge
Infertility	Not covered
Outpatient Diagnostic Laboratory and Radiology *(standard procedures)*	No charge
Complex Radiology (PET, MRI)	No charge
Outpatient Surgery	No charge
Outpatient Physical/Rehabilitation Therapy	$10 copay
Urgent Care *(your medical group/other medical group)*	$25 copay/ $50 copay
Emergency Room *(Copay waived if admitted)*	$250 copay (in or out of plan area)
Retail Prescription Drugs *(generic/preferred/non-preferred)*	$5 copay
Mail Order Prescription Drugs *(generic/preferred/non-preferred)*	Not available
Chiropractor Service	Not covered

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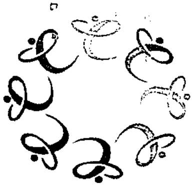

CALIFORNIA SCHOOLS VEBA

Kaiser and UnitedHealthcare

Bronze Plan Plan Summaries: 2019

Effective Date January 1 2019 - December 31, 2019

Important Notes:

- No Changes from 2018

Benefit Summary	Kaiser Bronze Plan What You Pay	UHC Bronze Plan What You Pay
Deductible (individual/family)	$4,500/$9,000	$3,000/$6,000
RX Deductible *(individual/family)*	$250/$250 (Brand Rx Only)	$250/$250 (Brand Rx Only)
Medical Plan Out-of-Pocket Maximum (individual/family)	$6,000/$12,000	$5,000/$10,000
RX Plan Out-of-Pocket Maximum (individual/family)	Integrated with Medical Plan	$1,600/$3,200
Health Reimbursement Account	None	None
PCP Office Visit	$50 copay (after deductible)	$60 copay
Specialist Office Visit	$50 copay (after deductible)	$85 copay
Preventive Care	No charge	No charge
Inpatient Hospital Care	40% copay (after deductible)	30% copay (after deductible)
Mental Health Services *(outpatient/inpatient)*	$50 copay (after deductible)/40% copay (after deductible)	$40 copay/30% copay (after deductible)
Substance Abuse Services *(outpatient/inpatient)*	$50 copay (after deductible)/40% copay (after deductible)	No charge
Infertility	Not covered	Not covered
Outpatient Diagnostic Laboratory (Standard Procedures)	No Charge	No charge
Complex Radiology (PET, MRI)	$150 copay per procedure (after deductible)	30% copay (after deductible)
Outpatient Surgery	40% copay (after deductible)	30% copay (after deductible)
Outpatient Physical/Rehabilitation Therapy	40% copay (after deductible)	$60
Urgent Care *(your medical group/other medical group)*	$50 copay (after deductible)	$60/$100
Emergency Room *(Copay waived if admitted)*	$250 (after deductible)	$300
Retail Prescription Drugs *(generic/preferred/non-preferred)*	$15 Generic (no deductible)/$35 Brand (after deductible)	$20 Generic/$40 Preferred Brand (after deductible)
Mail Order Prescription Drugs *(generic/preferred/non-preferred)*	$30 Generic (no deductible) /$70 Brand (after deductible)	$40 Generic/$80 Preferred Brand (after deductible)
Chiropractor Service	Not covered	Not covered

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